Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GERALD HILL MD
3802 21ST STREET SUITE A
LUBBOCK TX 79410

Carrier's Austin Representative Box
Box Number 19

Respondent Name
XL SPECIALTY INSURANCE CO

MFDR Date Received
March 21, 2012

MFDR Tracking Number
M4-12-2431-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From the Letter of Reconsideration dated December 17, 2011: "The date of service was May 17, 2011 and the original total amount billed on the HCFA-1500 was $650.00. **There has been a payment made at this time of $350.00, which leaves an outstanding balance of $300.00.** The denial on the EOR states the reason for the reduction being due to the worker's compensation fee schedule adjustment."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have reviewed the bills submitted and have confirmed they were processed appropriately per the provider's billing. …We have confirmed the recommendation of $350.00 was appropriate as no documentation was included that would allow for correct reimbursement for the impairment rating. Provider resubmitted with supporting documentation. This bill was reviewed and denied in full appropriately due to the recent updates to the Texas billing requirements. As the bill was denied in full, a recovery in the amount of $350.00 will be initiated until a corrected bill is obtained from the provider. As the billing provider included the name and NPI number of the referring provider in Box 17 on the HCFA, they will now need to also include the referring provider's state license number in Box 17a of the HCFA."

Response Submitted by: Flahive Ogden & Latson, P. O. Box 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 17, 2011	CPT Code 99456-WP	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. 28 Texas Administrative Code §133.10 sets out billing procedures for health care providers.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 21, 2011
   - W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

   Explanation of benefits dated January 11, 2012
   - 12 – (125) SUBMISSION/BILLING ERROR(S).
   - 12 – (125) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL.
   - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.
   - BL – ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS CLAIM WAS PAID IN ACCORDANCE WITH STATE GUIDELINES, USUAL/CUSTOMARY POLICIES, OR THE

Issues

1. Did the requestor complete the required data content or data elements in accordance with 28 Texas Administrative Code §133.10 (f)(1)(K)?
2. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §133.10 (f)(1)(K) states:

   (f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

   (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensable health care:

   (K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider shall enter the "0B' qualifier and the license type, license number, and jurisdiction code"

   Review of the requestors submitted DWC060, the initial and reconsideration CMS-1500, Box 17 lists J. Speight Grimes, M.D. as the referring provider however, Box 17a does not list the referring provider's license number. The Division finds that the requestor did not complete the required data content or data elements in accordance with 28 Texas Administrative Code §133.10(f)(1)(K).

2. Therefore, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		July 16, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.